BIODATA

Name | **Sex** | **Marital Status**

Home Phone | **Work Phone** | **Social Security No:**

Residence Address | **City** | **State** | **Zip**

Employer | **City** | **State** | **Employer's Ph:**

Present Position | **How long held?** | **Driver License No:** | **State**

Name of Spouse | **Spouse's Social Security No:** | **Work Phone.**

Spouse's Employer | **Address**

Referred by | **Address**

Who will pay for these services?

Name of Dental Insurance Company

I understand that I am financially responsible for all fees incurred for the services rendered by Dr Glen Kan. On any extensive dental work of $250 or more , I agree to make a down payment of 1/3 to 1/2 of the fee quoted at the time treatment is started, with the balance to be paid upon completion of service. If I fail to make the full payment within a 60 day period, my account may be turned over to a collection agency. In this case, I will be responsible for the additional expenses incurred by the agency. Interest of 1.5% per month will be charged on the amount I owe, as permitted by Maryland State Law.

Signature | **Date**